COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, NOVEMBER 2, 1999

COMMONWEALTH OF VIRGINIA, ex rel.

STATE CORPORATION COMMISSION

Ex Parte: In the matter of Adopting Rules Governing Independent External Review of Final Adverse Utilization Review Decisions (14 VAC 5-215-10 et seq.)

CASE NO. INS990252

ORDER TO TAKE NOTICE

WHEREAS, § 12.1-13 of the Code of Virginia provides that the Commission shall have the power to promulgate rules and regulations in the enforcement and administration of all laws within its jurisdiction, and § 38.2-223 of the Code of Virginia provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code of Virginia;

WHEREAS, § 38.2-5905 of the Code of Virginia provides that the Commission shall promulgate regulations effectuating the purpose of Chapter 59 of Title 38.2 of the Code of Virginia;

WHEREAS, the rules and regulations issued by the Commission pursuant to § 38.2-223 of the Code of Virginia are set forth in Title 14 of the Virginia Administrative Code;

WHEREAS, the Bureau of Insurance has submitted to the Commission a proposed regulation entitled "Rules Governing Independent External Review of Final Adverse Utilization Review Decisions," which is to be published in Chapter 215 of Title 14 of the Virginia Administrative Code as rules at 14 VAC 5-215-10 through 14 VAC 5-215-130;

WHEREAS, the Bureau of Insurance has recommended to the Commission that the proposed regulation be adopted with an effective date of February 15, 2000; and

WHEREAS, the Commission is of the opinion that a hearing should be held to consider the adoption of the proposed regulation;

THEREFORE, IT IS ORDERED THAT:

(1) The proposed regulation be attached hereto and made a part hereof as rules to be designated 14 VAC 5-215-10 through 14 VAC 5-215-130;

(2) All interested persons TAKE NOTICE that the Commission shall conduct a hearing in the Commission's Courtroom, 2nd Floor, Tyler Building, 1300 East Main Street, Richmond, Virginia 23219 at 10:00 a.m. on December 16, 1999, to consider the adoption of the attached regulation proposed by the Bureau of Insurance with an effective date of February 15, 2000;

(3) On or before December 2, 1999, any person desiring to comment in support of, or in opposition to, the proposed

regulation shall file such comments in writing with the Clerk of the Commission, Document Control Center, P.O. Box 2118, Richmond, Virginia 23218;

(4) On or before December 2, 1999, any person intending to appear and be heard at the hearing on the proposed regulation shall file written notice of his intention to do so with the Clerk of the Commission at the address above;

(5) All filings made under paragraphs (3) or (4) shall contain a reference to Case No. INS990252;

(6) An attested copy hereof, together with a copy of the proposed regulation, be sent by the Clerk of the Commission to the Bureau of Insurance in care of Deputy Commissioner Gerald A. Milsky, who forthwith shall give further notice of the proposed adoption of the regulation by mailing a copy of this Order, together with a draft of the proposed regulation, to all insurers licensed by the Commission to write accident and sickness insurance in the Commonwealth of Virginia and all health services plans, health maintenance organizations, and dental or optometric services plans licensed by the Commission under Chapters 42, 43, and 45, respectively, of Title 38.2 of the Code of Virginia; and

(7) The Bureau of Insurance shall file with the Clerk of the Commission an affidavit of compliance with the notice requirements of paragraph (6) above.

Chapter 215.

Rules Governing Independent External Review of Final Adverse Utilization Review Decisions.

14 VAC 5-215-10. Scope and purpose.

A. This chapter shall apply to all utilization review entities as that term is defined in 14 VAC 5-215-30 of this chapter, the issuer of a covered person's policy or contract of health benefits, and covered persons.

B. This chapter shall not apply to utilization performed under contract with the federal government for utilization of patients eligible for hospital services under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) or under contract with a plan otherwise exempt from the operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

This chapter shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

C. The purpose of this chapter is to set forth rules to carry out the provisions of Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia so as to provide: (i) a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions made by a utilization review entity; (ii) procedures for expedited consideration of appeals in cases of emergency health care; and (iii) standards, credentials**,** and qualifications for impartial health entities.

14 VAC 5-215-20. Evidence of Coverage forms.

A. The right of appeal contained in this chapter shall commence with regard to final adverse decisions rendered on or after May 17, 2000. Evidences of Coverage affected by this chapter that are issued, extended, renewed, amended, or reissued on or after February 15, 2000, shall conform to the provisions of this chapter. Evidences of Coverage in force on February 15, 2000, shall be deemed to be in compliance with this chapter and may continue to be used until the date that they are extended, renewed,

amended, or reissued. If any provision of an Evidence of Coverage in force February 15, 2000, conflicts with provisions of this chapter, the Bureau of Insurance and the impartial health entity shall use the provision more beneficial to the covered person.

B. In the event of a final adverse decision, a utilization review entity shall provide to the covered person or treating health care provider requesting the decision a clear and understandable written notification of: (i) the right to appeal final adverse decisions to the Bureau of Insurance in accordance with the provisions of Chapter 59 of Title 38.2 of the Code of Virginia; (ii) the procedures for making such an appeal; and (iii) the binding nature and effect of such an appeal. The notice shall include a copy of the then current "APPEAL OF FINAL ADVERSE DECISION" form, or such other form or forms as may then be required by the Bureau of Insurance pursuant to 14 VAC 5-215-120.

14 VAC 5-215-30. Definitions.

The following words and terms, when used in this chapter, shall have the following meaning unless the context clearly indicates otherwise.

"Adverse decision" means a utilization review determination by the utilization review entity that the health care service rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health care service.

"Appellant" means the covered person, the covered person’s parent if the covered person is a minor, the covered person’s legal guardian, or the covered person’s treating health care provider acting with the consent of the covered person, the covered person’s parent, if the covered person is a minor, or the covered person’s legal guardian.

"Commission" means the Virginia State Corporation Commission.

"Commissioner" means the Commissioner of Insurance.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Emergency health care" means health care items and medical services furnished or required to evaluate and treat an emergency medical condition.

"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. "Emergency medical condition" also means those health care services that are necessary to treat a condition or illness of a covered person that if not treated within the time frame allotted for a standard review under this chapter will result in serious risk of harm to the health of the covered person.

"Evidence of Coverage" means any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Final adverse decision" means a utilization review determination made by a utilization review entity in: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition, whether before or after granting an expedited review; or (iii) a reconsideration of a prior adverse decision, and upon which a covered person or a treating health care provider acting with the consent of a covered person may base an appeal. For purposes of this chapter, a final adverse decision shall be deemed to have been made on the date that it is communicated to the covered person or treating health care provider.

"Treating health care provider" or "provider," means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness, and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. As

used herein, "utilization review" shall include, but shall not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered.

"Utilization review" shall also include determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. "Utilization review" shall not include any: (i) review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services; (ii) review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132, and 38.2-134 of the Code of Virginia.

"Utilization review entity" or "entity" means a person or entity performing utilization review.

14 VAC 5-215-40. Minimum appealable amount.

A. Appeals of final adverse decisions may be made to the Bureau of Insurance provided that the cost of the health care service or services to the covered person would exceed $500 if the final adverse decision is not reversed. The cost of the health care service or services shall be determined by the amount the covered person has paid or has incurred a legal obligation to pay for such service or services, as well as the amount that the covered person would be obligated to pay in the event that the final adverse decision is not reversed.

B. The health care service or services must meet the following criteria in order to be eligible for an external review as provided by this regulation:

1. The service or services, as described by the most recent published editions of the applicable International Classification of Diseases 9th Revision Clinical Modification, Physician's

Current Procedural Terminology, Diagnostic Related Groups, or other billing code, must have a minimum value, as measured by the cost to the covered person, that exceeds $500.

2. No covered person or provider shall engage in "bundling" techniques designed to combine the value of denied services such that the cost to the covered person of denied services artificially exceeds $500.

3. The Commissioner, or his designee, shall have the final undisputed authority to determine if the cost to the covered person of the denied services exceeds $500.

14 VAC 5-215-50. Appeals.

A. An appeal of a final adverse decision made by a utilization review entity shall be submitted to the Bureau of Insurance within 30 days of the final adverse decision. The appeal shall be made by: (i) completing and signing a copy of the then current "Appeal of Final Adverse Decision" form, or such other form or forms as may then be required by the Bureau of Insurance pursuant to 14 VAC 5-215-120; (ii) completing and signing an "Authorization to Release Medical Information" in a form and manner required by the Bureau of Insurance; and (iii) forwarding a check or money order made payable to the "Treasurer of Virginia" in the amount of $50. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity that made the final adverse decision.

B. The $50 fee required to file an appeal may be waived or refunded for good cause shown upon a determination by the Bureau of Insurance that payment of the filing fee will cause undue financial hardship for the covered person. Such determination shall be based upon information provided on the "Appeal of Final Adverse Decision" form then required by the Bureau of Insurance, and any supplemental information required by the Bureau of Insurance. The decision of the Bureau of Insurance as to whether good cause has been shown that payment of the filing fee will cause undue financial hardship shall be final.

C. A preliminary review of the appeal shall be conducted by the Bureau of Insurance or its designee to determine the following: (i) that the person on whose behalf the appeal has been filed is, or

was, a covered person at the time the health care service in question was requested; (ii) that the appellant satisfies the definition of "appellant" set forth in 14 VAC 5-215-30; (iii) that the benefit or service that is the subject of the appeal reasonably appears to be a covered service for which the cost to the covered person would exceed $500 if the final adverse decision is not reversed; (iv) that all other appeal procedures available to the appellant have been exhausted, except in the case of an appeal accepted as one requiring expedited review; and (v) that the appeal is otherwise complete and filed in accordance with this section. The Bureau of Insurance shall not accept an appeal that does not meet the foregoing requirements.

D. The preliminary review shall be conducted within five working days of receipt of all information and documentation necessary to conduct the preliminary review.

E. The Bureau of Insurance shall notify the appellant and the utilization review entity in writing within three working days of the completion of the preliminary review whether the appeal has been accepted for review, and if not accepted, the reason or reasons therefor.

F. The appellant, the treating health care provider, if not the appellant, and the utilization review entity shall provide to the Bureau of Insurance or its designee copies of all medical records relevant to the final adverse decision within 10 working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal. The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

G. The Bureau of Insurance, or its designee, may request additional medical records from the appellant, the treating health care provider, if not the appellant, or the utilization review entity. Such medical records shall be provided to the entity making the request, whether the Bureau of Insurance or its designee, within 10 working days of the request. The confidentiality of these medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. Failure to comply with the request within the required time may result in dismissal of the appeal or reversal of the final adverse decision at the discretion of the Commissioner of Insurance.

H. If an appeal that is reviewed as an expedited appeal by a utilization review entity results in a final adverse decision, the utilization review entity shall take the following actions immediately: (i) notify the person who requested the expedited review of the final adverse decision; and (ii) notify the appellant, by telephone, telefacsimile, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance without the necessity of providing the justification required pursuant to 14 VAC 5-215-80 A. The notification shall be followed within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal to the Bureau of Insurance may be filed. A copy of this written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

I. If a request for an expedited review is denied by a utilization review entity, the entity shall take the following actions immediately: (i) notify the appellant of the decision by telephone, telefacsimile, or electronic mail; and (ii) inform the appellant that the appellant has the right to file a request for an expedited appeal with the Bureau of Insurance pursuant to 14 VAC 5-215-80 A. This notification shall be followed within 24 hours by a written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal to the Bureau of Insurance may be filed. A copy of the written notice shall be retained by the utilization review entity and included with any materials forwarded to the Bureau of Insurance in the event the utilization review entity's decision is appealed to the Bureau of Insurance.

J. If the Bureau of Insurance, or its designee, determines that a request for an expedited review which has been reviewed in accordance with subsection I of this section does not meet its criteria for an expedited review, the appellant shall be notified in writing by the Bureau of Insurance or its designee within two working days from the time such determination is made. The notice shall instruct the

appellant wishing to pursue the appeal to contact the issuer of coverage and request a review through the standard review process of the issues for which an expedited review was sought.

14 VAC 5-215-60. Impartial health entity.

The Bureau of Insurance shall contract with one or more impartial health entities to perform the review of final adverse decisions made by utilization review entities. The impartial health entity shall examine the final adverse decision and determine whether the decision is objective, clinically valid, compatible with established principles of health care, and appropriate under the terms of the contractual obligations to the covered person. The impartial health entity shall issue its written recommendation affirming, modifying, or reversing the final adverse decision within 30 working days of the acceptance of the appeal by the Bureau of Insurance in the case of a standard review as set forth in 14 VAC 5-215-70. In the case of an expedited review, the impartial health entity shall issue its written recommendation within five working days of the acceptance of the appeal by the Bureau of Insurance.

14 VAC 5-215-70. Standard review.

A. The Bureau of Insurance, within two working days following its acceptance of an appeal, shall assign an impartial health entity with which it has contracted pursuant to 14 VAC 5-215-60 to conduct an external review and to provide a written recommendation to the Commissioner as to whether to affirm, modify, or reverse the final adverse decision.

B. In reaching a recommendation, the assigned impartial health entity is not bound by any decisions or conclusions reached during the utilization review entity's utilization review process.

C. The utilization review entity shall provide to the assigned impartial health entity all documents, medical records, and other information relevant to the final adverse decision within 10 working days of the receipt of the notice required in 14 VAC 5-215-50 F.

D. Except as provided in subsection E of this section, failure of the utilization review entity to provide the documents, medical records and information within the time specified in subsection C of this section shall not delay the conduct of the external review.

E. 1. Upon receipt of a notice from the assigned impartial health entity that the utilization review entity, appellant, or the treating health care provider, if not the appellant, has failed to provide the documents, medical records, and information within the time specified in subsection C of this section, the Commissioner may terminate the external review and make a decision to affirm or reverse the final adverse decision.

2. Immediately upon making the decision pursuant to subdivision 1, the Commissioner shall communicate his decision in writing to the assigned impartial health entity, the appellant and the utilization review entity.

F. The assigned impartial health entity shall review all of the relevant information and documents received pursuant to subsection C and any other information submitted in writing by the appellant that has been forwarded to the impartial health entity by the Bureau of Insurance.

G. In addition to the documents and information provided pursuant to subsection C above, the assigned impartial health entity, to the extent the information is available and the impartial health entity considers them appropriate, shall consider the following in making its recommendation:

1. The treating health care provider's recommendation;

2. Consulting reports from appropriate health care providers and other documents submitted by the utilization review entity, the appellant, or the covered person's treating health care provider, if not the appellant;

3. The terms of coverage under the covered person's health benefit plan;

4. The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

5. Any applicable clinical review criteria developed or used by the utilization review entity.

H. The assigned impartial health entity shall include in its recommendation provided pursuant to 14 VAC 5-215-60:

1. A general description of the reason or reasons for the request for external review;

2. The date the impartial health entity received the assignment from the Bureau of Insurance to conduct the external review;

3. The dates the external review began and concluded;

4. The date of its recommendation;

5. The principal reason or reasons for its recommendation;

6. The rationale for its recommendation; and

7. References to the evidence or documentation, including the practice guidelines or clinical criteria, considered in reaching its recommendation.

I. 1. Immediately upon receipt of the assigned impartial health entity's recommendation, the Commissioner shall review the recommendation to ensure that it is not arbitrary or capricious.

2. The Commissioner shall notify the appellant and the utilization review entity in writing of the decision to uphold or reverse the final adverse decision by issuing a written ruling affirming, modifying or reversing the final adverse decision. The written ruling shall bind the covered person and the issuer of the covered person's policy or contract for health benefits to the same extent to which each would have been bound by a judgment entered in an action at law or in equity with respect to the issues which the impartial health entity may examine when reviewing a final adverse decision.

3. The Commissioner shall include in the notice sent pursuant to subdivision 2:

a. The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner that the Commissioner considers appropriate, the information provided by the assigned impartial health entity supporting its recommendation; and

b. If applicable, the principal reason or reasons why the Commissioner did not follow the assigned impartial health entity's recommendation.

4. Upon notice of a decision pursuant to subdivision 1 reversing the final adverse decision, the utilization review entity immediately shall approve and provide, or provide reimbursement for, any and all medical services that were the subject of the final adverse decision.

14 VAC 5-215-80. Expedited review.

Appeals presented to the Bureau of Insurance as requiring emergency health care shall be evaluated as follows.

A. Immediately upon receipt of an appeal indicating that emergency health care is required and otherwise meeting the requirements for review as provided in 14 VAC 5-215-50 C, the Bureau of Insurance shall consult with the impartial health entity to which the appeal normally would be assigned, and such entity shall determine if the appeal involves emergency health care.

B. If, after consultation with the impartial health entity, a determination is made by the Bureau of Insurance that the appeal does not qualify for an expedited review, the person making the request for the expedited review shall be notified within two working days of receipt by the Bureau of Insurance of sufficient information to support the request for expedited review. The declination by the Bureau of Insurance to provide an expedited review shall not preclude the appellant from resuming the normal appeal process within the utilization review entity or from filing a request for a standard review by the Bureau of Insurance, provided the requirements set forth in 14 VAC 5-215-50 A have been met.

C. Immediately upon acceptance of an appeal for expedited review, the Bureau of Insurance shall notify the utilization review entity and the appellant by the most expeditious means available, including telephone, telefacsimile, or electronic mail, of their right to submit information and supporting documentation. Such information shall be submitted to the Bureau of Insurance or the impartial health entity within two working days of the acceptance of the appeal.

D. Upon the acceptance of the appeal for expedited review the Bureau of Insurance shall assign the appeal to an impartial health entity for clinical review as provided in 14 VAC 5-215-60. The impartial health entity shall review the appeal and make a decision as required under 14 VAC 5-215-60 as

soon as possible consistent with the medical exigencies of the case, but in no event more than five working days after its receipt of the appeal.

14 VAC 5-215-90. Reconsideration of final adverse decision.

The utilization review entity may reconsider its final adverse decision that is the subject of the external review at any time.

A. Reconsideration by the utilization review entity of its final adverse decision shall not delay or terminate the external review.

B. The external review may be terminated if the utilization review entity decides, upon completion of its reconsideration, to reverse its final adverse decision and provide coverage or payment for the health care service that is the subject of the final adverse decision.

C. 1. Immediately upon making the decision to reverse its final adverse decision, the utilization review entity shall notify the appellant, the assigned impartial health entity, and the Commissioner in writing of its decision.

2. The assigned impartial health entity shall terminate the external review upon receipt of the notice from the utilization review entity sent pursuant to subdivision 1.

14 VAC 5-215-100. Payment of fees.

Any utilization review entity that: (i) reverses a final adverse decision that has already been assigned to an impartial health entity for review; or (ii) is required to provide previously denied services as a result of the Commissioner's written ruling shall be responsible for the payment of the actual costs, as determined by the Bureau of Insurance, incurred by the Commission in the course of such review. This payment shall be made within 30 days of notification to the utilization review entity of the actual costs incurred.

14 VAC 5-215-110. Standards, credentials, and qualifications of the impartial health entity.

A. In order to qualify to perform either standard or expedited external reviews pursuant to this chapter and § 38.2-5900 et seq. of the Code of Virginia an impartial health entity shall have and maintain

written policies and procedures that govern all aspects of the standard and expedited external review processes that include, at a minimum:

1. A quality assurance mechanism in place that ensures:

a. That external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

b. The selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the impartial health entity and suitable matching of reviewers to specific cases;

c. That the confidentiality of medical records is maintained in accordance with the confidentiality and disclosure laws of the Commonwealth; and

d. That any person employed by or under contract with the impartial health entity adheres to the requirements of this chapter as well as § 38.2-5900 et seq. of the Code of Virginia; and

2. An agreement to maintain and provide to the Commission the information set out in § 38.2-5900 et seq. of the Code of Virginia.

B. All clinical peer reviewers assigned by an impartial health entity to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions as the covered person's;

3. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A, an impartial health entity shall not be affiliated with or a subsidiary of, nor be owned or controlled by a health plan, a trade association of health plans, or a professional association of health care providers.

D. 1. In addition to the requirements set forth in subsections A, B, and C, to be qualified to perform an external review of a specified case pursuant to this chapter, neither the impartial health entity selected to conduct the external review nor any clinical peer reviewer assigned by the impartial health entity to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. The utilization review entity that made the final adverse decision that is the subject of the external review;

b. The covered person whose treatment is the subject of the external review;

c. Any officer, director or management employee of the utilization review entity that made the final adverse decision which is the subject of the external review;

d. The health care provider, the health care provider's medical group or independent practice association recommending the health care service or services subject to the external review;

e. The facility at which the recommended health care service was or would be provided; or

f. The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical peer reviewer of the impartial health entity has a material, professional, familial or financial conflict of interest for purposes of subdivision D 1, the Commissioner may take into consideration situations where the impartial health entity to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the impartial health entity to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subdivision D 1, but the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest sufficient to disqualify the impartial health entity or the clinical peer reviewer from conducting the external review.

14 VAC 5-215-120. Modification of forms.

The Bureau of Insurance shall be permitted to modify forms prepared for use in connection with this chapter as needed without requiring amendment to this chapter. Any modifications shall be provided to all insurers licensed to market health insurance, all licensed health maintenance organizations, and all licensed health services plans in the form of an administrative letter prepared by the Bureau of Insurance and sent by regular mail to such licensee's mailing address as shown in the records of the Bureau of Insurance. Failure to receive such administrative letter shall not be cause for exemption or grounds for noncompliance with the requirements set forth in this chapter. All original and subsequently modified forms shall be filed by the Bureau of Insurance for publication in the Virginia Register of Regulations.

14 VAC 5-215-130. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Chapter 215 Forms

INSTRUCTIONS FOR COMPLETING THE APPEAL OF FINAL ADVERSE DECISION FORM

IMPORTANT TERMS AND DEFINITIONS

APPEAL OF FINAL ADVERSE DECISION

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Effective Date - February 15, 2000

State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741

INSTRUCTIONS FOR COMPLETING THE APPEAL OF FINAL ADVERSE DECISION FORM

Please Read Carefully Before Completing the Form

Before attempting to complete the attached form, please read the following instructions carefully. We also recommend that you review the form itself as well as the "Important Terms" list attached.

The law requires that in order to be "appealable" the cost to the covered person of the services or procedures in question would exceed $500 if the final adverse decision is not reversed. Please verify the cost of the service(s) before requesting an appeal of a final adverse decision.

1. **Name & Address**
   Please type (or print) the covered person's full name. Include the address, daytime telephone number, date of birth, sex and policy number, certificate number, or other identifying number of the covered person.

2. **Appellant Information**
   This section is to be completed by the appellant who is making the appeal on behalf of the covered person. This section does not need to be completed if the covered person is requesting the external review on his own behalf.

3. **Name of the Managed Care Health Insurance Plan**
   Please provide the name, address and telephone number of the Managed Care Health Insurance Plan (MCHIP). The MCHIP name should be the same as the insurance company or health maintenance organization providing the covered person's coverage. If the covered person is covered by insurance through an employer, please provide the name, address and phone number of the employer, if available. If the plan is self-funded, please indicate that information as well (optional).

4. **Describe the Covered Person's Situation**
   Please clearly and accurately describe the nature of the circumstances surrounding the covered person's request for an appeal of a final adverse decision. Attach **copies** of any pertinent and essential documentation that supports your request, including the letter from the covered person's MCHIP denying coverage for the service or services you want reviewed. This could include, but is not limited to, correspondence from treating physicians and medical records.

5. **Expedited Review**
   In certain situations, an expedited review of an appeal of a final adverse decision may be requested. If delay of the service(s) or procedure(s) will immediately threaten the life or health of the covered person, please indicate this by checking the "yes" box. Attach documentation that supports that the situation involved is immediately life or health threatening.

6. **Filing Fee Waiver**
   Please note that the $50 filing fee may be waived. If you wish to request that the filing fee be waived, please describe the reason or reasons for the request and provide supporting documentation.

7. **Authorization/Authorization to Release Medical Information**
   Please carefully read the "Authorization" section on the "Appeal of Final Adverse Decision" form and the separate "Authorization to Release Medical Information" form included with this package. Information that you provide or authorize to be released may be shared with an impartial health entity. The signature of the covered person or the covered person's parent or legal guardian is required on both of these forms in order for the appeal of the final adverse decision to occur.

State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741

IMPORTANT TERMS AND DEFINITIONS

"**Appellan**t" - means the covered person, the covered person's parent if the covered person is a minor, the covered person's legal guardian, or the covered person's health care provider acting with the consent of the covered person, the covered person's parent, if the covered person is a minor, or the covered person's legal guardian.

"**Cost of Service**"- the total amount paid by the covered person for a rendered service or the assumed liability for that service by the covered person for a rendered service. The law requires that in order for an appeal of a final adverse decision to occur, the cost to the covered person of the service if the final adverse decision is not reversed must be exceed $500.

"**Emergency Medical Condition**"- the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Emergency medical condition also means those health care services that are necessary to treat a condition or illness of a covered person that if not treated within the time frame allotted for a standard review under this chapter will result in serious risk of harm to the health of the covered person.

"**Expedited Review**"- a review of a final adverse decision that is provided in an urgent manner due to the fact that the covered person has an emergency medical condition.

"**Final Adverse Decision**"- means a utilization review decision made by a utilization review entity in: (i) declining to grant an expedited review in a situation involving an alleged emergency medical condition; (ii) declining to provide coverage or services for an alleged emergency medical condition, whether before or after granting an expedited review; or (iii) a reconsideration of a prior adverse decision, and upon which a covered person or provider acting with the consent of a covered person may base an appeal. In other words, and except in emergency situations, it is the final decision of the plan after the internal appeal process has been exhausted.

"**Impartial Health Entity**"- an organization selected by the Bureau of Insurance that performs, under contract with the Bureau of Insurance, reviews of final adverse decisions. The Bureau of Insurance is not an impartial health entity.

"**Managed Care Health Insurance Plan**" or "**MCHIP**"- an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange and pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier.

"**Self-funded Plan**"- an employer sponsored group health plan administered by an insurance company or MCHIP. The employer actually pays for claims that are processed and administered by the insurance company or MCHIP.

State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741

APPEAL OF FINAL ADVERSE DECISION

If you meet the definition of an **Appellant**[1], and have had a request for approval of health care service(s) denied by a **Managed Care Health Insurance Plan (MCHIP)**, you may have the right to an external review of the **MCHIP's** decision. An **impartial health entity** selected by the Bureau of Insurance will review the appropriateness of the **MCHIP's** decision, and make a recommendation to the Commissioner of Insurance as to whether the health care service(s) should be covered. In order for such a review to occur, the appellant must complete and sign this form. Additionally, the appeal in question must meet the following criteria:

1. The **cost of service** in question must exceed $500;
2. The appeal must be filed within 30 days of the final adverse decision by the **MCHIP**;
3. The **MCHIP's** internal appeal process must have been exhausted (except for expedited reviews); and
4. A $50 filing fee must be submitted with this form by check or money order made payable to the Treasurer of Virginia. This fee is nonrefundable unless it can be demonstrated that paying the fee constitutes a financial hardship to the covered person (see item 6 on the following page).

Additional instructions and definitions of key terms for completing this form are attached. If you have questions while completing this form or if you have questions that are not addressed in the instruction form, you may contact The Office of the Managed Care Ombudsman toll free at (877) 310-6560, or locally at (804) 371-9032, for assistance.

The decision reached as a result of this external review process is binding upon the covered person as well as the issuer of the covered person's policy to the same extent that each would be bound by a judgment entered in a court action at law or in equity.

I request an external review of the **MCHIP's** final adverse decision by an **impartial health entity** as chosen by the Bureau of Insurance. I certify that the covered person's **MCHIP's** internal appeals have been exhausted, or that the requirements for an **expedited review** have been met. I enclose copies of all correspondence or other documents which may include patient medical records, correspondence from medical providers and/or the **MCHIP** relating to this matter that may help the Bureau of Insurance and the **impartial health entity** in its evaluation of my request for review.
(Please type or print clearly all requested information in the spaces provided, or use additional pages, if necessary.)

1. Name of the Covered Person: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Daytime Phone Number: (_____) _____

Date of Birth: _____ Sex: _____

ID# (Policy or Certificate number): _____

2. If you are an appellant **other than** the covered person, please tell us your name and what your relationship is with the covered person.

_____

_____

3. Complete Name of **MCHIP**: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone number: (_____) _____

Is this health coverage provided through an employer? ☐ Yes ☐ No

If yes, please provide the employer's name, address, and telephone number:

_____

_____

_____

Is this a **self-funded plan**? ☐ Yes ☐ No (This question can be left unanswered if you are unsure.)

4. On a separate sheet of paper, please describe the situation you are seeking help with and describe the service(s) or procedure(s) in question:

Please send us a copy of the letter informing the covered person of the MCHIP's **Final Adverse Decision**. Include information such as medical records from the medical provider of the covered person that supports that the service in question is medically appropriate and necessary. Attach copies of any information that you or the covered person's health care provider believe is essential to the requested review.

5. Are you requesting an expedited **review**? ☐ Yes ☐ No

If yes, please provide documentation that covered person's situation involves an **emergency medical condition** where a delay in care would place their life or health in serious jeopardy.

6. Are you requesting a waiver of the $50 filing fee? ☐ Yes ☐ No

If yes, please provide the reason and documentation to support the claim that paying the $50 filing fee would cause financial hardship to the covered person.

AUTHORIZATION

I understand and agree that a copy of this form and any information I provide may be forwarded to the **MCHIP** and to the **Impartial Health Entity**.

_____ _____

Signature of Appellant (if not the covered person) Dated

_____ _____

Signature of Covered Person or Covered Person's Parent or Legal Guardian Dated

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization must be signed by the covered person or the covered person's parent (if the covered person is a minor) or the covered person's legal guardian.

Any health care provider of services or supplies, insurance company, or any other organization, institution or person that has a record or knowledge regarding the covered person named below and such person's health, is hereby authorized to furnish to the Bureau of Insurance, or its designated impartial health entity, information concerning services or supplies provided or proposed to be provided to such covered individual.

If I am not the covered person listed below, I hereby certify that I am authorized by law to execute this authorization on the covered person's behalf.

This authorization is given for the purpose of conducting an external review of a final adverse decision made by a utilization review entity. This authorization is valid for 90 days from the date below.

Printed Name of Covered Person: _____

Social Security # of Covered Person: _____ — _____ — _____

Covered Person's Date of Birth: _____

Signature of Covered Person: _____

OR

Signature of Parent or Legal Guardian of Covered Person: _____

Date: _____